Active Therapeutic Solutions
259 Grange Rd, Guelph ON N1E 6R5
Dr. Edward Finoro & Associates

REGISTRATION FORM

PATIENT INFORMATION

Patient's last name: First: Middle:	☐ Mr. ☐ Mrs.	☐ Miss ☐ Ms.	Marital status: Single / Mar / Div / Sep / Wid	
Street address:	Date of Birth: (DD/MMM/YYYY - -		Email Address:	
Home phone no.: ( ) -	City:	Province:	Post Code:	
Occupation:	Employer:		Employer phone no.: ( ) -	

Chose clinic because/Referred to clinic by (please check one box): ☐ Dr. ☐Chiropractor ☐ Massage Therapist ☐ Clinic ☐ Hospital

☐ Family ☐ Friend ☐ Location ☐ Plaza ☐ Yellow Pages ☐ Web Site ☐ Internet ☐ Sign ☐ Other

Other family members seen here:

WORKERS COMPENSATION (WSIB) (ONLY IF APPLICABLE)

☐ WSIB Injury Date of Accident: dd /mm /yy Claim Number: SIN#:

Occupation:	Employer:	Employer address:	Employer phone no.: ( ) -

Time off work? ☐ Yes ☐ No How Long? Contact at Work:

Description of Accident?

AUTO INSURANCE & INSURANCE INFORMATION (ONLY IF APPLICABLE)

Date of Accident: dd /mm /yy	Claim Number:	Adjuster Name:
Did you require medical attention?: ☐ Y ☐ N	Did you require an ambulance?: ☐ Y ☐ N	Did you have x-rays?: ☐ Y ☐ N

Please indicate primary insurance:

Subscriber's name:	Social Insurance. No.: - -	Birth date: / /	Group no.:	Policy no.:	Co-payment: $

Patient's relationship to subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other

Name of secondary insurance (if applicable):	Subscriber's name:	Group no.:	Policy no.:

Description of Accident:

CONSENT AND VERIFICATION

The above information is true to the best of my knowledge. I authorize my insurance benefits where applicable be paid directly to Active Therapeutic Solutions. I understand that I am financially responsible for any balance not paid by my insurer or WSIB in circumstances whereby the claim has been rejected. I also authorize Active Therapeutic Solutions to release any information required to process my claims to my insurer or the WSIB.

I acknowledge and agree that I am aware of the **24 hr cancellation policy** of Active Therapeutic Solutions and sign consent to the **full billing rate** of that missed treatment session. Extenuating circumstances are exempt. **Missed appointments** are not covered by insurance benefit or WSIB and must be paid by the **patient/client**.

Patient/Guardian signature / / *Date dd/mmm/yyyy*

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Date:	
Patient:	
Dr.	

HEALTH HISTORY QUESTIONNAIRE

All questions contained in this questionnaire are strictly confidential and will become part of your medical record.

Name:	Last:	First:	Middle:	☐ M ☐ F	**DOB:**	/ / dd/mmm/yyyy	**Age:**
Marital status:	☐ Single	☐ Partnered	☐ Married	☐ Separated	☐ Divorced	☐ Widowed	
Family Doctor:					**Date of last physical exam:**		

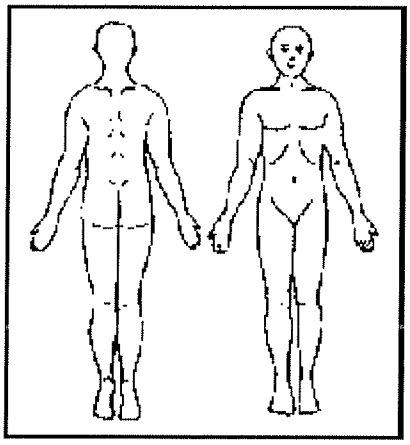
Type of Therapy Wanted: ☐ **Chiropractic Care** ☐ **Physio/Rehab Therapy** ☐ **Unknown Let Dr. Decide**

Type of Care Management: ☐ **Acute Relief Care** ☐ **Corrective Care** ☐ **Maintenance/Supportive Care**

PERSONAL HEALTH HISTORY

Current Compliant:				
When did it occur?				
Have you had this before?				
What was the cause?				
Where do you feel it the most?				
Aggravations?				
Pain at night?				
Associated Symptoms?				
Character of Pain:	☐ Sharp	☐ Constant	☐ Burning	☐ Improving
	☐ Shooting	☐ Intermittent	☐ Pins & Needles	☐ Worsening
	☐ Ache	☐ Night Pain/Wakes from Sleep	☐ Numb	☐ Same since onset

Please indicate the severity of your pain (x): Least ☐1☐2☐3☐4☐5☐6☐7☐8☐9☐10 Worst



Please outline on the diagram the area of your discomfort and any radiation of pain.

Doctor's Notes/Orthopaedic Findings:

DTR's: Upper Right C5 C6 C7 Left C5 C6 C7
Lower Right L4 L5 S1 Left L4 L5 S1

Vitals's: BP: HR: WT: TMP:

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Other Doctor's or Therapists seen for this condition: ☐ Yes ☐ No **Type of Treatment:** **Results:**

Has this pain occurred before:

Nature of Injury: ☐ **Work Injury (WSIB)** ☐ **Auto Accident Injury** ☐ **Other**

Surgeries

Year	Reason	Hospital

Tests/X-ray/MRI/CT/Ultra Sound/Bone Scan/ Hospitalizations **Lab/Hospital/Imaging Clinic**

Year	Reason	Hospital/Lab/Imaging Clinic

List your prescribed drugs and over-the-counter drugs, such as vitamins and inhalers

Name the Drug	Strength	Frequency Taken

Allergies

HEALTH HABITS AND PERSONAL SAFETY

ALL QUESTIONS CONTAINED IN THIS QUESTIONNAIRE ARE OPTIONAL AND WILL BE KEPT STRICTLY CONFIDENTIAL.

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Exercise	☐ Sedentary (No exercise)				
	☐ Mild exercise (i.e., climb stairs, walk 3 blocks, golf)				
	☐ Occasional vigorous exercise (i.e., work or recreation, less than 4x/week for 30 min.)				
	☐ Regular vigorous exercise (i.e., work or recreation 4x/week for 30 minutes)				
Diet	Are you dieting?			☐ Yes	☐ No
	If yes, are you on a physician prescribed medical diet?			☐ Yes	☐ No
Caffeine	☐ None	☐ Coffee	☐ Tea	☐ Cola	
	# of cups/cans per day?				
Alcohol	Do you drink alcohol?			☐ Yes	☐ No
	If yes, what kind?				
	How many drinks per week?				
Tobacco	Do you use tobacco?			☐ Yes	☐ No
	☐ Cigarettes – pks./day	☐ Chew - #/day	☐ Pipe - #/day	☐ Cigars - #/day	
	☐ # of years	☐ Or year quit			
Personal Safety	Do you live alone?			☐ Yes	☐ No
	Do you have frequent falls?			☐ Yes	☐ No
	Do you have vision or hearing loss?			☐ Yes	☐ No

FAMILY HEALTH HISTORY

	AGE	SIGNIFICANT HEALTH PROBLEMS		AGE	SIGNIFICANT HEALTH PROBLEMS
Father			**Children**	☐ M ☐ F	
Mother				☐ M ☐ F	
Sibling	☐ M ☐ F			☐ M ☐ F	
	☐ M ☐ F			☐ M ☐ F	
	☐ M ☐ F		**Grandmother** *Maternal*		
	☐ M ☐ F		**Grandfather** *Maternal*		
	☐ M ☐ F		**Grandmother** *Paternal*		
	☐ M ☐ F		**Grandfather** *Paternal*		

MENTAL HEALTH

Is stress a major problem for you?	☐ Yes	☐ No
Do you feel depressed?	☐ Yes	☐ No
Do you panic when stressed?	☐ Yes	☐ No
Do you have trouble sleeping?	☐ Yes	☐ No

WOMEN ONLY

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Number of pregnancies Number of live births		
Are you pregnant or breastfeeding?	☐ Yes	☐ No
Any urinary tract, bladder, or kidney infections within the last 12 months?	☐ Yes	☐ No
Any blood in your urine?	☐ Yes	☐ No
Any hot flashes or sweating at night?	☐ Yes	☐ No
Do you have menstrual tension, pain, bloating, irritability, or other symptoms at or around time of period?	☐ Yes	☐ No

MEN ONLY

Do you usually get up to urinate during the night?	☐ Yes	☐ No
If yes, # of times		
Do you feel pain or burning with urination?	☐ Yes	☐ No
Any blood in your urine?	☐ Yes	☐ No
Have you had any kidney, bladder, or prostate infections within the last 12 months?	☐ Yes	☐ No
Date of last prostate and rectal exam?		

OTHER PROBLEMS

Check if you have, or have had, any symptoms in the following areas to a significant degree and briefly explain.

☐ Cough	☐ Deafness	☐ Pregnant Due Date:
☐ Shortness of breath	☐ Vision Loss	☐ Neck Pain
☐ Bronchitis	☐ Loss of Sensation	☐ Upper Back Pain
☐ Asthma	☐ Diabetes	☐ Mid-Back Pain
☐ High Blood Pressure	☐ Epilepsy	☐ Shoulder Pain
☐ Low Blood Pressure	☐ Arthritis	☐ Arm Pain
☐ Hx of Heart Attack	☐ Cancer	☐ Leg Pain
☐ Hx of Stroke	☐ Osteoporosis	☐ Knee Pain
☐ Pace maker	☐ Hepatitis	☐ Elbow Pain
☐ COAD	☐ Tuberculosis	☐ Ability to sleep
☐ Skin Allergies/Irritations	☐ AIDS/HIV	☐ Other pain/discomfort:
☐ Psoriasis/Eczema	☐ SARS	☐ Other pain/discomfort:

Doctors Notes:

Diagnosis:

Treatment Plan:

Referral:

Extended Health Benefit Information

PRIMARY COVERAGE:

Patient Name: _____ Date of Birth: _____
DD/MM/YYYY

Insurance Company: _____

Policy Holder Name: _____ Date of Birth: _____
DD/MM/YYYY

Plan Number: _____ Certificate/Contract ID: _____

SECONDARY COVERAGE:

Insurance Company: _____

Policy Holder Name: _____ Date of Birth: _____
DD/MM/YYYY

Plan Number: _____ Certificate/Contract ID: _____

	Coverage Year	Amount of coverage per year	Coverage %	Amount of coverage per visit	Doctor Referral	Deductible
Chiropractic						
Physiotherapy						
Massage Therapy						
Orthotics						
Health Spending Account						
Acupuncture						

Additional Orthotic Coverage Questions:

Can the orthotics be dispensed by a chiropractor? ☐ YES ☐ NO

Are there any other requirements? ☐ YES ☐ NO

If yes, please describe: _____

_____